U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 30 April 2003

CASE NO. 2001-BLA-1021

In the Matter of:

WESLEY EUGENE CLARK
Claimant

v.

PEABODY COAL COMPANY
Employer

and

OLD REPUBLIC INSURANCE CO., INC.
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-In-Interest

Appearances:

Frederick K. Muth, Esq.
For the Claimant

Paul E. Frampton, Esq.
For the Employer

Before: GERALD M. TIERNEY
Administrative Law Judge

DECISION AND ORDER - AWARDING BENEFITS

This matter arises from a request for modification of a previous decision that denied

Claimant Black Lung Benefits.[1]

Claimant filed his most recent application for Black Lung Benefits on December 5, 1998 (DX 1). The claim came before Administrative Law Judge Robert J. Lesnick for hearing on January 25, 2000 (DX 58). On July 31, 2000, Judge Lesnick issued a Decision and Order Denying Benefits (DX 63). Claimant filed a request for reconsideration (DX 64). On September 26, 2000, Judge Lesnick denied that request (DX 65).

On February 15, 2001, within one year of Judge Lesnick's decision, Claimant filed a request for modification (DX 67). On July 18, 2001, the District Director transferred the matter to the Office of Administrative Law Judges to be set for hearing (DX 72).

I scheduled a formal hearing on March 27, 2002 in Beckley, West Virginia. Claimant sought to withdraw his request for a hearing. The Director and Employer objected to Claimant's request. Claimant advised the Court that if Director's request for a hearing was granted, he would waive his right to the hearing and request a decision on the record.

By Order dated April 10, 2002, I vacated my February 1, 2002 Order of Dismissal. I granted Claimant's request to decide the case on the record. The record consists of 72 Director's Exhibits.

Claimant is 75 years old (DX 1). He worked at least 26 years as a coal miner (DX 63). Peabody Coal Company was properly identified as the responsible operator (DX 63). Claimant has one dependent, his wife Donnie (DX 63).

Claimant's current 1998 application is his fifth claim for Black Lung Benefits (DX 1, 29-32). Claimant acknowledged that he cannot prove that he suffers from a totally disabling respiratory or pulmonary impairment (DX 58, 63). Claimant seeks to prove entitlement by invoking the §718.304 irrebuttable presumption (DX 58, 63).

Section 718.304 provides an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if that miner is suffering from a chronic dust disease of the lung which:

(a) When diagnosed by chest x-ray yields one or more large opacities (greater than one centimeter in diameter) and would be classified in Category A, B, or C;

(b) When diagnosed by biopsy or autopsy, yields massive lesions in the lung; or

(c) When diagnosed by other means which could reasonably be expected to yield the

[1] The Black Lung Benefits Act, as amended, is codified at 30 U.S.C. §901 with its implementing regulations found at Title 20 of the Code of Federal Regulations. The following abbreviations are used in this decision: DX - Director's Exhibit.

results described in paragraph (a) or (b).

The condition described by the above criteria is frequently referred to as "complicated pneumoconiosis," although that term does not appear in the statue or the regulation. *Double B Mining, Inc. v. Blankenship,* 177 F.3d 240 (4th Cir. 1999).

Judge Lesnick did not invoke the §718.304 irrebuttable presumption. He acknowledged that there were chest x-ray readings identifying a large opacity consistent with complicated pneumoconiosis. However, Judge Lesnick denied benefits based on a combination of the x-ray evidence and the CT scans. He also found the physicians who rendered opinions finding pneumoconiosis were inconsistent.

In filing his request for reconsideration, Claimant argued that Judge Lesnick's finding that the CT scan evidence was more reliable that the chest x-ray evidence was in direct conflict with a then-recent Fourth Circuit decision, *Eastern Associated Coal Corp. v. Director, OWCP* [*Scarbro*], 220 F.3d 250 (4th Cir. 2000) (DX 64). Claimant suggested that Judge Lesnick minimized the importance of the chest x-ray evidence.

In his decision on reconsideration, Judge Lesnick explained that he did not find the CT scan evidence definitive evidence or more persuasive than the x-ray but that the CT scan evidence helped to clarify the evidence already presented by the x-ray reports (DX 65). Judge Lesnick explained that the finding he made with regard to the CT scan evidence was in addition to his finding regarding the chest x-ray evidence. He added that independent of his finding with regard to the CT scan evidence, the chest x-ray evidence did not establish pneumoconiosis by a preponderance of the evidence.

Claimant filed a request for modification on the grounds that Judge Lesnick made a mistake in a determination of fact. It is Claimant's position that the evidence in this case clearly shows that he suffers from a condition which would trigger invocation of the §718.304 irrebuttable presumption.

In evaluating a claim under §718.304, I must first evaluate the evidence under each prong and then weigh together all the evidence to determine whether it, as a whole, supports invocation. *Scarbro, supra; see also Melnick v. Consolidation Coal Co.,* 16 BLR 1-31 (1991).

Evaluating the chest x-ray evidence pursuant to §718.304(a), I note omissions in Judge Lesnick's summary of that evidence. Judge Lesnick did not report that both Drs. Patel and Gaziano identified a category A large opacity on Claimant's February 24, 1999 chest x-ray (DX 11-13). Nor did Judge Lesnick report that Drs. Siner and Westerfield identified a category A large opacity on Claimant's March 19, 1999, March 30, 1999, and June 24 1999 chest x-rays (DX 42).

Inclusion of the additional readings changes the balance of the readers who found a large

opacity verses the readers who did not. Although determining the preponderance of the evidence is not a matter of "counting" chest x-ray readings on "each side," I find that a change in the result is necessary. In Judge Lesnick's July 31, 2000 Decision and Order, he concluded that Claimant did not prove complicated pneumoconiosis since forty-four of the sixty-four x-ray x-rays of record were determined to be negative for pneumoconiosis. However, this determination did not take into account the progressive nature of pneumoconiosis. When the x-ray evidence is viewed in light of the year in which it was taken, the ratio of the negative readings to the positive readings is less disparate. The earlier x-rays of record, the majority of which were taken before Claimant filed this present claim, do not establish the existence of pneumoconiosis. In 1995, based on the March 24, 1995, June 9, 1995, and June 13, 1995 x-rays, all of the fifteen physicians who provided interpretations concluded that Claimant did not have pneumoconiosis. In 1996, three physicians found the February 21, 1996 and October 10, 1996 x-rays to be positive for pneumoconiosis and three physicians found the slides to be negative. Thereafter, in 1998, seven physicians found that no pneumoconiosis and one physician found COPD with multiple small pulmonary nodules.

In 1999, the majority of the physicians who reviewed Claimant's slides identified complicated pneumoconiosis. Eighteen physicians, sixteen of which were duly qualified readers, found A opacities, while sixteen equally qualified physicians determined that Claimant did not have pneumoconiosis. Furthermore, the June 24, 1999 x-ray, the most recent x-ray which was read by more than one physician was read as positive with A opacities by five duly qualified physicians and negative by only three. Because an ALJ may proportion more weight to the most recent chest x-ray evidence, I find that Claimant does meet his burden of proof at §718.304(a). What the amended summary of the chest x-ray evidence now reflects is that the majority of the equally qualified radiological experts, based on the most recent chest x-rays, concluded that a large opacity exists. Thus, Claimant does prove, by the preponderance of the chest x-ray evidence, the existence of a complicated pneumoconiosis. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (en banc); *Tolascik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983).

There is no biopsy or autopsy evidence to consider at §718.304(b).

Relevant to §718.304(c), there is evidence of an "other means" that would reasonably be expected to yield the results decided in §718.304(a) or (b). The CT chest scan evidence is considered here. *Melnick, supra.*

Claimant's Counsel made much of Judge Lesnick's statement that he considered the CT scan evidence more reliable than the chest x-ray evidence. Judge Lesnick responded that it was not his opinion that the CT scan was the definitive evidence on the issue but rather the CT scan helped clarify the evidence already presented by the chest x-ray reports.

There was testimony from two radiological experts, Drs. Cappiello (DX 50) and Wheeler (DX 54). Both physicians were aware of the controversy regarding the presence of a large

opacity. They explained the factors which led them to reach their respective conclusions. Dr. Cappiello found that there was chest x-ray evidence warranting the classification of a large category A opacity; Dr. Wheeler did not.

Dr. Cappiello testified: "In all probability, it is pneumoconiosis, and of a complicated nature." Dr. Cappiello added that if you really wanted to prove it, you would have to remove the opacity, measure it, and examine it pathologically. He noted that this would require much effort and would subject Claimant to a significant risk.

The CT chest scans were discussed. Dr. Cappiello pointed out that the purpose of Dr. Younis' CT report was to rule out cancer, not to make a diagnosis of pneumoconiosis. *See* DX 41. Dr. Cappiello explained that if the scan's purpose was to diagnose pneumoconiosis, it would have been a high resolution CT and not a diagnostic CT as Dr. Younis reported. Dr. Cappiello stated:

> [I]f you wanted to rule out or rule in pneumoconiosis, if you wanted to make a stronger case, I think you would either have to get the CT films themselves and look at them a second time from that point of view [to diagnose pneumoconiosis], or subject [Claimant] to a high resolution CT though that area with thin slices and look at those.

See also DX 52 at 11-12.

Thus, it is the testimony of Dr. Cappiello which provides the foundation for the evidentiary value of the CT scan as an another tool to diagnose the condition described by §718.304.

There are reports of four CT scans. A number of physicians reviewed these results.

In April 1998, Dr. Duren reported that a then-recent CT scan revealed nodular densities in the right upper lung consistent with granulomatous changes and small mediastinal nodes less than one centimeter (DX 47). The actual report of this CT scan was not in the record or reviewed by others.

Drs. Wheeler and Scott, both board-certified radiologists and B-readers, reviewed the films of a March 12, 1999 CT scan (DX 44). Neither reader identified pneumoconiosis. Dr. Scott stated that Claimant has nodular infiltrates and or fibrosis in the upper lungs which is "most likely due to TB" or an "unknown activity". Dr. Wheeler specifically ruled it out and concluded that Claimant has granulomatous disease, compatible with TB, but stated that TB is "far more likely to involve the mid and lower chest, not the upper lungs and apices."

Dr. Zaldivar, a board-certified pulmonary specialist, who evaluated Claimant most recently in May 1999, requested a high resolution CT scan to rule out the existence of pneumoconiosis

(DX 24). It was performed on June 9, 1999. He interpreted the films as showing findings that would be consistent with Claimant's history of coal workers' pneumoconiosis but added that the nodules were prominent and recommended a follow up CT scan in three months to document the stability of the process (DX 24). By letter dated June 16, 1999, Dr. Zaldivar explained that the nodules do not have the appearance of complicated pneumoconiosis and are more representative of a previous infective process or simple pneumoconiosis. However, he stated that given the fact that Claimant was a coal worker, he could not completely rule out coal workers' pneumoconiosis and that a biopsy would be the only way to determine the true nature of the nodules (DX 24).

On January 3, 2000, Dr. Zaldivar concluded that the CT scan and the x-rays do not indicate complicated pneumoconiosis. He said that Claimant had simple pneumoconiosis. Dr. Zaldivar added that Claimant's condition may be due to a previous infection or to the residuals of pneumoconiosis" and he recommended that a biopsy be taken (DX 45).

On January 4, 2000, Dr. Zaldivar was deposed. He testified that there was no evidence of complicated pneumoconiosis. He reiterated his belief that Claimant has non-specific nodules in the upper lungs which may be due to a "previous infection or may be due to early simple pneumoconiosis." He said that the nodules are consistent with the type seen in a fungus infection, histoplasmosis, healed TB, sarcoidois, or coal workers' pneumoconiosis (DX 52). However, he stated that there is no evidence that Claimant ever suffered from TB (DX 52).

Drs. Wheeler and Scott reviewed the films of the June 9, 1999 and June 16, 1999 CT scans. (DX 36). Neither identified pneumoconiosis. Dr. Wheeler specifically ruled it out. He said that the small nodules located in the upper region of the lungs are compatible with granulomatous disease, TB, or an unknown activity. He stated that TB is more likely than histoplasmosis. Dr. Scott based his negative reading on the fact that Claimant has nodules in the upper right portion of the lung which is "probably due to TB" (DX 36).

Dr. Younis also interpreted the June 16, 1999 CT scan (DX 41). Dr. Younis identified abnormalities consistent with occupational disease but did not mention the size of the nodules or mention the presence of complicated pneumoconiosis (DX 50).

Dr. Cappiello discussed the June 16, 1999 CT scan (DX 50). He concluded that Claimant has complicated pneumoconiosis with the presence of large opacities. He based his decision on the fact that calcifications are not apparent. He said that calcifications are typical in granuloma, histoplasmosis and even TB, but not complicated pneumoconiosis. Dr. Cappiello also explained why Claimant was not suffering from any other type of disease. He said that Claimant did not have a typical neoplastic disorder because of the multiplicity of the nodules and their close proximity. He explained that there was not a significant change in size of the nodules during the three month period between March and June 1999, which he would expect to see in cancer. Lastly, he stated that the because the nodules were located in the upper lobes and not in lower regions of the lungs, Claimant's condition was more consistent with pneumoconiosis.

Pulmonary specialists Drs. Zaldivar (DX 24, 45, 52), Tuteur (DX 49, 55), and Fino (DX 46, 59) reviewed the evidence including the CT scan reports. They did not find evidence supporting the diagnosis of a condition described at §718.304.

Dr. Rasmussen diagnosed "complicated pneumoconiosis" based on Dr. Patel's chest x-ray reading (DX 9). Dr. Rasmussen did not have the opportunity to address the conflicting evidence on the issue or the CT scans.

The majority of the above-mentioned physicians concluded that the CT scans do not show the existence of complicated pneumoconiosis. Thus, I find that the CT scan evidence alone does not establish complicated pneumoconiosis.

Because the chest x-ray evidence conflicts with the CT scan evidence, I must now make an "equivalency determination" by looking at all of the relevant evidence presented to see if complicated pneumoconiosis is present. *Eastern Associated Coal Corporation v. Director, OWCP*, 220 F.3d 250 (2000). Circuit Judge Niemeyer explained that when an equivalency determination is made,

> Evidence under one prong can diminish the probative force of evidence under another prong it the two forms of the evidence conflict. Yet 'a single piece of relevant evidence' can support an ALJ's finding that the irrebuttable presumption was successfully invoked if that piece of evidence outweighs conflicting evidence in the record.

Id at 256 citing *Lester v. Director*, 993 F.2d at 1145.

Weighing together the evidence at §§718.304(a)-(c), I find that the chest x-ray evidence outweighs the conflicting evidence in the record. A majority of the equally-qualified readers found the existence of a large opacity based on the most recent chest x-ray evidence. Also, the chest x-ray evidence is consistent with Claimant's 26 year history of coal mine employment and the lack of evidence that Claimant previously suffered from TB.

Furthermore, although all but two physicians read the CT scans as negative for complicated pneumoconiosis, I find that less probative weight must be attached to such evidence since the physicians' opinions are inconsistent. Dr. Duren based his negative reading of complicated pneumoconiosis on the fact that the nodules are consistent with granulomatous changes and small mediastinal nodes. Dr. Scott and Dr. Wheeler determined that Claimant's nodules were more consistent with TB. Dr. Wheeler, however, explained that if Claimant had TB, it would be more likely that the nodules would be located in the lower lungs and not the upper lungs. Dr. Zaldivar concluded that the nodules were due to a previous infection or simple pneumoconiosis. He said that they were consistent with a fungus infection, hisloplosmosis, healed TB, sarcoidois, or coal workers' pneumoconiosis but that there is no evidence that Claimant ever

suffered from TB.

In contrast, Dr. Younis identified abnormalities consistent with complicated pneumoconiosis based on the nodules. Dr. Cappiello also found complicated pneumoconiosis with large opacities because Claimant did not have apparent calcifications and the nodules were located in the upper region of the lungs. He specifically explained why Claimant did not suffer from any other type of disease.

Due to the foregoing, I find that the preponderance of the evidence, considered as a whole, is sufficient to invoke the §718.304 presumption. I have reviewed the entire record. I find that a mistake was made in the determination of complicated pneumoconiosis which would warrant modification of the previous denial decision. An award of benefits is appropriate.

Claimant's request for modification is granted.

Onset of Benefits

Where benefits are awarded on modification, and because a petition for modification merges with the originally filed claim, Claimant is entitled to receive benefits the date of the originally filed claim. *Garcia v. Director, OWCP*, 12 B.L.R. 1-24 (1988). Therefore, Claimant is entitled to receive benefits commencing on December 5, 1998.

Attorney Fee

Because no application for approval of attorney fees has been submitted to this Court, thirty days is hereby allowed to Claimant's counsel to do so. The application must contain a service sheet which shows that all parties have been served, including Claimant. Thereafter, pursuant to §725.365 and §725.366 of the Act, the parties have ten days following receipt of the application to file objections.

ORDER

The claim of Wesley Eugene Clark for benefits under the Act is hereby **GRANTED**.

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GERALD M. TIERNEY
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Order may appeal it to the Benefits Review Board within 30 days from the date of this Order by filing a Notice of Appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a Notice of Appeal must also be served on Donald S. Shire, Esq., Associate Solicitor for Black Lung Benefits. His address is Room N-2117 Frances Perkins Building, 200 Constitution Avenue, N.W., Washington, D.C. 20210.